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ABSTRACT

The Board of Professional Affairs (BPA) of the American Psychological Association is dominated by the health care providers whose agenda in issuing accreditation standards and influencing state licensing requirements may be as much to protect the clinician from less expensive competition as it is to protect the client. Tension exists between the BPA and the Society for Industrial Psychology members whose clients are typically organizations rather than individuals. Restrictive licensing and accreditation by the BPA are not relevant to the typical industrial/organizational scientist/practitioner and may even preclude his practicing as a psychologist. While industrial/organizational psychologists are supportive of their health care provider colleagues' efforts to attain parity with other professions and to protect third-party therapy dollars from encroachment from nonpsychologists, they are opposed to the restraints advanced by BPA which would position non-health care provider members against their health care provider colleagues over professional turf issues. (Author/NRB)

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Industrial Organizational Psychology: Today's Critical Issues

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Running Head: TODAY'S CRITICAL ISSUES

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Abstract

The Board of Professional Affairs is dominated by the health care providers whose agenda in issuing accreditation standards and influencing state licensing requirements may be as much to protect the clinician from less expensive competition as it is to protect the client. Our client is typically an organization, not an individual. Accordingly, restrictive licensing and accreditation championed by BPA, ostensibly to protect the invididual client, are not relevant to the typical industrial/organizational scientist/practitioner and may even preclude our practicing as "psychologists." While industrial/organizational psychologists are supportive of our health care provider colleagues' efforts to attain parity with other professions and to protect third-party "therapy dollars" from encroachment from nonpsychologists, we are opposed to the restraints advanced by BPA which would pit us against our colleagues over professional "turf" issues.

Industrial/Organizational Psychology: Today's Critical Issues

In setting the objectives for this symposium, the then Chair of the Board of Professional Affairs (BPA) Bruce Bennett (personal communication, January 10, 1985) had "...hoped that the moderators would consider potential areas of tension and commonality among the specialties ... and discuss specifically any relevant BPA issues." As our presenters will detail, members of the Society for Industrial and Organizational Psychology (Division 14) have some very real problems with "turf" issues, including the direction APA policy is headed regarding generic versus specialty standards, designation, specialty recognition, and licensing (see Howard & Lowman, 1985, for licensure overview). (Many of these same professional "turf" issues are presently being addressed by the Task Force on the Structure of APA and their recommendations are eagerly awaited.)

The areas of tension between Division 14 and BPA revolve around the interrelated issues of self-regulation and governmental regulation in terms of the health care providers, who want tighter and more inclusive control, versus the non-health care providers, including members of Division 14, who want to be free from unnecessary, burdensome, counter-productive regulation. These tensions have in part been exacerbated over the past two decades by the growth of practice-oriented health care providers and the decline of research-oriented members (Commission on the Organization of APA).

The Great Society impetus leading to the Rehabilitation Act of 1965 stimulated an unprecedented expansion of rehabilitation services which in turn forced APA to deal with who the "qualified psychologist" was that would staff the programs funded by the Rehabilitation Act. It was not until third-party reimbursement beckoned clinicians that their perceived need to "protect the turf" crystallized the credentialing issue. APA's efforts at defining Standards for Providers of Psychological Services in 1967 and again in 1977 have been in response both to this "turf" question as well as to defining ethical standards of professional behavior. The Standards for Providers, however, have become one of the primary sources of tension between Divison 14 and the health care providers whose agendas dominate BPA.

The fundamental question to be addressed in APA's quest for defining who the "qualified psychologist" is: Who is to be protected, the client or the clinician? While in theory, the client/consumer of psychological services is free to elect that type of professional service that meets his or her needs, in reality choice is dictated by third-party reimbursement policies, since the majority of those individuals receiving private psychotherapy are reimbursed by a third party. Obviously by defining minimum standards of training and experience APA signals state regulatory agencies which, by adopting the minimum standards, give the APA definitions the force of law regarding who is a "qualified" psychologist. Most, but not all, state

licensing boards have accepted the PhD as a mimimum requirement for defining who is to be recognized as a "psychologist." These efforts at defining mimimum standards, however, have been largely the creation of the health care providers, whose interests are at least as much economic as ethical.

Third-party reimbursement has never been a part of the industrial/organizational (I/O) scientist/practitioner's world of work, and our problem in all of the efforts to create standards, designations, and specialty guidelines is that they have all without exception been built on the medical model of the health care provider. While APA has traditionally emphasized generic standards and generic licensing, Division 14 has continued to make the point that the I/O scientist/practitioners have substantially different practices from the typical health care provider and these differences are detailed in Paul Sackett's paper. Therefore, minimum training and experience requirements defining the clinical model of practice are not relevant to the I/O scientist/practitioner.

Furthermore, whether intended or not, any standards, designations and specialty guidelines adopted by APA have an immediate consequence for I/O psychologists because such guidelines and standards when adopted at the state level define who can practice under the designation "psychologist." The states' authority derives from their policing power to prevent injury or exploitation of the public and is accomplished by

ensuring that "psychologists" providing professional services to the public are minimally qualified using APA-developed standards, designations, and specialty guidelines (Reisner, 1985).

While such regulation may be viewed as a means of protecting the individual, as Paul Sackett points out, the individual served by the health care provider is not the organization served by the I/O scientist/practitioner. The legitimate interests of the state in protecting the public and the ostensible interest of BPA in protecting the client are not as readily apparent to us where the clients of Division 14 are organizations and not individuals per se.

I/O psychologists are already accountable to aggrieved individuals applying to and employed by our client organizations which are prohibited from discriminating in hiring, promotion, and discharge by: Title VII of the Civil Rights Act of 1964; the Age Discrimination in Employment Act of 1967; and a myriad of state and local laws including the Equal Employment Opportunity Commission's Uniform Guidelines on Employee Selection Procedures which have been adopted by 28 states (Goldstein, 1985). I/O psychologists are also accountable in terms of employees' right to privacy by: the Federal Privacy Act of 1974; laws limiting use of polygraph testing for job applicants in 20 states; laws giving employees access to their personnel files in 9 states; and laws restricting use of arrest records in the hiring process in 12 states. Compensation systems developed by

I/O psychologists are also regulated by the Equal Pay Act of 1963 prohibiting sex discrimination in pay.

I/O psychologists' accountability to aggrieved individuals and classes of individuals in court has in many ways strengthened our practice. While it often seems as if our standards of practice are being determined in the courtroom, the fact is that our practice has flourished without our fighting to limit other nonpsychologists who can deliver the same services to client organizations. I/O psychologists do not have an organizational behavior franchise.

"Solid state psychology," for example, is a growing corporate personnel practice with the introduction of computer-based test interpretation software written and marketed in many instances by nonpsychologists (Mitchell, 1985). Division 14 is as likely to dry up Niagara Falls as it is to stem the tide of this modern-day cottage industry by fighting to protect "our" turf in the organization. We can neither keep nonpsychologists from developing job-related selection procedures nor prevent organizations from adopting computer-based test interpretation systems with unknown validity. Our approach to self regulation has been to issue the Principles for the Validation and Use of Personnel Selection Procedures to keep our membership current, to inform client organizations about the quality of service they can expect from an industrial/organizational psychologist and more generally to

educate both the market as well as the courts in terms of what is considered to be generally accepted professional standards.

What distinguishes Division 14 members from nonpsychologists is our common core of research and measurement skills and our research-generated knowledge base. We compete in the market by delivering to organizations, among other services, valid selection procedures measured and described in terms understood both by management, our client, and by the courts. Our vitality as a division is in part due to the diversity of backgrounds and training of our membership as well as our willingness to compete by delivering a quality product to a demanding market, not because we have dissipated our energies trying to inhibit our competition. In this context, it is ironic that the most serious threat to our identity as scientist/practitioner psychologists comes not from competition in the market but from within APA.

In our judgment, BPA fails to recognize that the practice of the I/O psychologist is not at the individual level although we are ultimately accountable to an aggrieved individual in court. Our client is typically an organization and our contribution is typically at the systems level, not at delivering a service to an individual client. As such, the restrictive licensing and certification provisions and curriculum accreditation championed by BPA, ostensibly to protect the individual client, are not responsive to the I/O scientist/practitioner and may even preclude our practicing as "psychologists."

Lest we fail to recognize the likely agenda behind BPA's signaling state boards, governmental regulation of the profession also serves other purposes than protecting the individual, and these include the control of competition. By limiting entry into practice, the state effectively protects health care providers from competition from the social workers and marriage and family counselors whose growth in the past decade has exceeded even that of clinical psychologists.

Writing in the New York Times , Goleman (1985) noted that while there were an estimated 15,000 clinical psychologists in 1975, today they number approximately 33,000, a growth of 120% in the past decade. The figures for the growth in the number of social workers are even more explosive. In 1975, there were an estimated 25,000 clinical social workers. The number of social workers today is estimated to be 60,000, a growth of 140%, and in absolute numbers, almost twice the number of social workers as clinicians.

The New York Times also noted the change in the health care provider's market place that is in my opinion has been and continues to be the driving force behind BPA's enthusiasm for specialty standards, designation, specialty recognition and licensing. According to the Times, social workers now provide the bulk of therapy in institutions, and growing numbers are treating more affluent, private clients, thus encroaching on the more expensive psychiatrists' and psychologists' turf.

The social workers, in turn, are being challenged by marriage and family counselors, who as a group have shown the most explosive growth of all. While before 1964 no state recognized them, and today no more than nine do, there are by some estimates at least 28,000 marriage and family counselors in practice, and perhaps far more. No one knows their exact number, because in most states there is no licensing requirement for them.

Lest we fail to recognize the winners and losers, a benefit to the individual client/consumer growing out of this competition is more accessible therapy in a wider range of prices and techniques. With a finite number of "therapy dollars" to share, however, the market is becoming price sensitive, since a great many more people are seeking therapy from increasingly diverse sources offering therapy at a wider price range than ever before.

In the absence of consensus regarding what constitutes an acceptable therapeutic outcome, the client/consumer may perceive a better return on his or her third-party reimbursed "therapy dollar" from the less expensive counselor. Of course, if the client/consumer can only collect third-party reimbursement for the services of a licensed "psychologist," then the clinicians' competition from less costly social workers and counselors can be contained.

According to the Times, psychology leads the way among nonmedical psychotherapists in getting states to license their

profession, a prerequisite for persuading insurance companies to reimburse psychologists for psychotherapy. This is a strategic competitive advantage for clinicians in the market place since the majority of payments for private psychotherapy are not from the patient, but from third parties such as insurance companies and the armed forces.

To date, 40 states now have 'freedom of choice' laws that require insurance companies to reimburse psychologists for therapy if patients prefer them to psychiatrists. Social work associations have managed to get laws passed in 35 states licensing social workers, but have persuaded only 14 to pass laws requiring insurers to reimburse social workers for psychotherapy. Marriage and family counselors have managed to get state licensing or certification in only nine states and only California requires insurance companies to reimburse them for therapy. Clearly there are real market pressures on the clinicians' traditional turf.

In conclusion, it is not that Division 14 is not supportive of our health care provider colleagues' efforts to seek parity with these other professions. We are simply opposed to those restraints advanced by BPA which would pit us against our colleagues over professional "turf" issues. Part of this problem is simply that those influencing APA policy don't know what the I/O concerns are. I/O psychology has flourished at least in part because as our outgoing President, Ben Schneider, put it (1985):

(I)n our Society we have some built-in mechanisms for keeping each other challenged; challenged to do good work, to share it with each other, and to accept alternative perspectives on the work. In other words, I think the wonder of us is that we are willing to stand up to each other and value each others' perspective on what is important. What this buys us, I think, is perspective on the world of work. By this I mean that no one of us seems to be so dumb as to think we have the answer; we know and understand that from an alternative perspective, whether theoretical or practical, another answer may be equally useful and good. Any science or practice characterized by such openness can only be powerful; a profession characterized by both is terrific - and interesting.

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